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Virginia Primary Care Association Comments on the Impact of Medicaid Revitalization Efforts in Virginia on Community Health Centers / Federally Qualified Health Centers

Good morning. My name is Rick Shinn. I am the Director of Public Affairs for the Virginia Primary Care Association, representing Federally Qualified Health Centers (FQHCs), commonly called Community Health Centers (CHCs), that provide primary health care services in medically underserved areas of the Commonwealth. Our members operate 73 health care sites across Virginia, with the mission of helping those persons and communities most in need. As non-profit community based safety net providers, twenty percent of our patients, eighteen percent of total revenues, and thirty-two percent of revenues derived from services comes from Medicaid. Change to Medicaid is obviously an issue that is significant to our patients and our centers.

Florida has often been mentioned during discussions on Medicaid Revitalization. To let you know, in Florida, the community health centers were invited to be actively involved at the state level during their discussions, and the state embraced several of the concepts of their community health centers. Even the Governor of Florida has embraced FQHCs as a partner in their reform. The Florida Section 1115 waiver incorporated several items related to FQHCs – our request is that this committee and DMAS look to community health centers as a partner in this effort, since we provide primary care to a large portion of the Medicaid population in Virginia.

Critical to the financial stability of our Federally Qualified Health Centers and look-alike programs is the special consideration in federal regulations on reimbursement for Medicaid to FQHCs. With Medicaid reform, there is a grave concern that reform efforts may either intentionally, or more likely by oversight, harm the financial stability of FQHCs, a critical part of the health care safety net in Virginia. The “wrap-around” system that Virginia uses to work with FQHCs needs to be protected.

FQHCs by definition only work in medically underserved areas or with medically underserved populations. Hence, all Medicaid managed care networks should be required to contract with FQHCs and their sites in those areas. This is another feature of the Florida plan.

Once interesting feature in Florida is that they were able to obtain a Section 1115 waiver that established a Low Income Pool. Not limited to hospitals only, this pool was designed so that providers with certain high levels of uninsured would also be able to use those funds for provider services. Virginia should seriously consider this as a viable option for handling the ever pressing issue of how to provide services to those lacking health insurance. With the data available from FQHCs, distribution of these funds could be managed equitably to ensure that areas with high rates of uninsured would be targeted. I believe the amount that Florida allocated was capped at one billion dollars per year for the next five years.

On enhanced benefits plans, Florida has given special status to FQHCs and included FQHC visits as a credit towards their Enhanced Benefits Accounts. The rationale for this is that FQHCs provide a true medical home, a continuity of care, and a range of services designed to reduce the costs of health care. As an example, one of these programs is our Health Disparities Collaboratives, designed to target specific high cost high incidence disease. Currently, we operate health disparities collaboratives for diabetes, cardiovascular, asthma and prevention. Over half of our health centers offer these programs, with two additional organizations planning to offer these programs this fall. We would urge Virginia to consider the benefits of working with our community health centers in the area of disease management.

In addition, Florida has actually decided to contract with their community health centers for their disease management model and some of the HMOs in Florida will be contracting to use that model through their systems as well.

The quality of care and disease management programs implemented by Community Health Centers have been noted in various studies and articles. Our health centers can be an instrumental asset in helping the Commonwealth as it seeks to contain costs and to improve service delivery, particularly for those who are considered medically underserved. At least one study has noted

that community health centers lower the cost of provider services to Medicaid recipients by 30%. CHCs have been recognized nationally for their ability…"to ensure quality care at lower costs by providing a regular source of primary & preventive care services, thus, reducing ER use and avoidable hospitalizations…" as noted by the Kaiser Commission on Medicaid & the Uninsured (March 2006.)

Since so many of our patients are Medicaid recipients, an area of concern for FQHCs is the potential impact on reimbursement and the potential impact on the financial stability of community health centers. A portion of the funding for our centers comes from federal Section 330 grants, designed to help bring health care services to the uninsured and poor in Medically Underserved Areas. In order to safeguard those funds from subsidizing other federal programs, Congress has passed regulations that govern reimbursement for FQHCs. This reimbursement system is critical to insure the financial stability of our health centers, and in continuing the mission of serving those in need.

We ask that special consideration be given to this issue, and that protections for FQHC and FQHC look-alike programs be covered in any bills, statutes, waivers, state plan amendments and regulations that may guide Medicaid reform in Virginia. We are willing to work closely with this committee, with DMAS and with the General Assembly on this effort.

One of the goals of revitalization is to look at ways to contain the growth of Medicaid expenditures. As a way to help providers manage costs, an area that needs to be fully discussed is the implementation and utilization of electronic health records. Our centers are currently exploring this issue, and estimate that the cost will be approximately two million dollars for state-wide implementation in community health centers, not including any special modifications or other needs to meet potential standards that may be developed for handling Medicaid records. This represents an enormous cost to non-profit safety net providers.

Our Community Health Centers/FQHCs are not opposed to reform. We simply ask that our Community Health Centers/FQHCs be a partner with the state in guiding this reform, and that community health centers also be asked for input on reform efforts. We need further, detailed

discussion with this committee and DMAS on these critical issues for Community Health Centers/FQHCs. Please call upon us for any additional information we can provide as we work together to meet the needs of the Commonwealth and her citizens.

Kindest regards,

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